Be Smart About Your Heart
Control the ABCs of Diabetes
A1C
Blood Pressure
Cholesterol

CENTRAL DISTRICT HEALTH DEPARTMENT

Check ____

Cash ____

CLIENT DATA FORM

How many hours did you fast? _____

Have we tested you before? **Y** **N**

SEX: √ ❒ **Female** ❒ **Male** **BIRTH DATE:** _____ -- _____ -- _____
month day year

NAME (Print) _____ _____
LAST name **FIRST name**

ADDRESS (number/street) _____

CITY _____ **STATE** _____ **ZIP**_____ **PHONE** _____

YOUR AGE _____ **YOUR HEIGHT**_____ **YOUR WEIGHT**_____

	Circle one
CURRENT HISTORY	
Do you have a medical provider?	**Y N**
Are you currently using tobacco?	**Y N**
Have you quit tobacco use recently?	**Y N**
How long ago? _____ **months** _____ **years**	
Do you currently do some form of physical activity on a regular basis? (at least 3 times/week)	**Y N**

DIABETES	
Does a parent, grandparent, brother, or sister have diabetes? √ **Check box if unknown** ❒	**Y N**
Do you have diabetes? If yes, do you control diabetes by:	**Y N**
Medicine: Y N Diet: Y N Exercise: Y N	

HEART HEALTH	
Do you take a prescribed cholesterol-lowering medication?	**Y N**
Do you take a prescribed blood pressure medication?	**Y N**
Are you taking herbal or over the counter products for cholesterol or blood pressure?	**Y N**

CONSENT FOR BLOOD SAMPLE:

I consent to having a blood sample drawn for the purpose to determine my blood cholesterol level. The screening will be kept confidential. **UNDER 18 a parent signature is required**

_____ _____ _____
Signature **Parent/Guardian** **Today's Date**

THIS FORM ALSO AVAILABLE ON CDHD WEB SITE:
www.cdhd.idaho.gov

9-2009

_____ /
BP Reading